PARENT QUESTIONNAIRE - SHORT FORM

Behavioral Health and Learning Evaluation

Child's Name & [Sponsor's] Social:	Today's Date:
Home Address:	
Parent's Phone Numbers – Home:	Work:

1. BEHAVIORS: *Check the box that best describes your child's behavior over the last week or so.*	*Are these behaviors currently a problem?* Never / Rarely	Occasionally	Often	Very Often
Fails to give close attention to details or **makes careless mistakes** in schoolwork.				
Has **difficulty sustaining attention** in tasks or activities.				
Does not listen when spoken to directly.				
Does not follow through on instructions and fails to finish schoolwork.				
Has **difficulties organizing** tasks and activities.				
Avoids, dislikes, or is **reluctant to engage in tasks** that require sustained mental effort.				
Loses things necessary for tasks or activities.				
Is **easily distracted** by extraneous stimuli.				
Is **forgetful** in daily activities.				
Fidgets with hands or feet or squirms in seat.				
Leaves seat in classroom or in other situations in which remaining seated is expected.				
Runs about or climbs excessively in situations in which remaining seated is expected.				
Has **difficulty playing** or engaging in leisure activities quietly.				
Is **"on the go"** or acts as if "driven by a motor."				
Talks excessively.				
Blurts out answers before questions have been completed.				
Has **difficulty waiting in line**.				
Interrupts or intrudes on others.				

2. PERFORMANCE: *Check the box that best describes your child over the last week or so.*	*Are these activities currently a problem?* **Above Average** 1	2	**Average** 3	4	**Problematic** 5
Getting ready in the morning					
Dinner hour behavior					
Overall mood					
Getting ready at bedtime					
Relationship with children his or her own age					
Relationship with parents					
Relationship with brothers and sisters					
Homework completion					
Getting homework to and from school					
Classroom assignment completion					
Organizational skills					
Participation in organized activities (e.g. teams)					
Overall school performance					
1.Reading					
2.Written Expression					
3.Mathematics					
4.Handwriting					

Medical Provider Use ONLY [any Often & Very Often is still problem; >6/9 = Diagnosis] 1-9=**Inattentive:** ____/ 9 10-18=**Hyperactive:** ____/ 9 **Performance** [any 'Problematic' needs addressing]: Y N

CONTINUED ON BACK

PARENT QUESTIONNAIRE – SHORT FORM (continued)

Child's Name:

3. SUMMARY: Please **summarize your child's <u>OVERALL</u> functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare your child's functioning in 3 settings-- home, school, and with peers, to "average children" his/her age that you are familiar with from your experience. **Please circle only one number.**

1	**Excellent** functioning / No impairment in settings
2	**Good** functioning / Rarely shows impairment in settings
3	**Mild** difficulty in functioning / Sometimes shows impairment in settings
4	**Moderate** difficulty in functioning / Usually shows impairment in settings
5	**Severe** difficulties in functioning / Most of the time shows impairment in settings
6	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
7	**Needs 24-hour <u>professional</u> care and supervision** due to severe behavior or gross impairment(s)

4. SIDE EFFECTS: *Has your child experienced any of the following side effects or problems in the past week?*	**Are these side effects currently a problem?** None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite *Explain below:*				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening *Explain below:*				
Socially withdrawn- decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors / Feeling shaky				
Repetitive movements, tics, jerking, twitching, eye-blinking *Explain below:*				
Picking at skin or fingers, nail biting, lip or cheek chewing *Explain below:*				
Sees or hears things that aren't there				
EXPLAIN/COMMENTS:				

5. TREATMENTS: What treatment(s) have you and your child been receiving since we last met?
(describe all that apply)

a. Counseling:

b. Help from the School:

c. Parenting Classes:

d. Medication (Name, Amount and Times of Day):

e. Do you need a prescription? YES NO

6. Are there any other problems you would like your Healthcare Provider to know about? Please comment:

Medical Provider Use Only **[Summary = any score of 4 or higher is significant & needs addressing] Impairment of Functioning: Y N**

Provider Signature: **Date:**